

PATIENT INFORMATION

The information provided in this form is vitally important in the planning of your surgical care. Omission of complete and accurate information to the physician could result in the delay or cancellation of your surgery as well as jeopardize the ability of the physician to provide the best possible care.

NAME: _____ DOB: ____/____/____ AGE: _____

FIRST MIDDLE LAST
SS#: ____/____/____ MALE/FEMALE RACE: _____ MARITAL STATUS: S M W D

ADDRESS: _____
STREET APT# CITY STATE ZIP

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____

ADDRESS: _____
STREET CITY STATE ZIP

PRIMARY INSURANCE INFORMATION: Please include the front and back copy of your insurance card(s).

INSURANCE PROVIDER: _____ PROVIDER PHONE #: _____

MEMBER ID #: _____ GROUP#: _____

POLICY HOLDER'S INFORMATION (If different than pt.):

NAME: _____ DOB: ____/____/____ SS#: ____/____/____

EMPLOYER: _____ PHONE: (____) ____-____ ADDRESS: _____

SECONDARY INSURANCE INFORMATION:

INSURANCE PROVIDER: _____ PROVIDER PHONE #: (____) ____-____

MEMBER ID #: _____ GROUP#: _____

POLICY HOLDER'S INFORMATION: NAME: _____

DOB: ____/____/____ SS# ____/____/____

EMPLOYER: _____ PHONE: (____) ____-____ ADDRESS: _____

ARE YOU RECEIVING DISABILITY BENEFITS? No Yes IF YES, LIST REASON(S):

PATIENT INFORMATION pg. 2

EMERGENCY CONTACT: _____ HOME PHONE #: (____) ____-_____
MOBILE #: (____) ____-____ RELATIONSHIP: _____

TRAVEL COMPANION OR TRANSPORT SERVICE FOR OUT-OF-TOWN PATIENTS ONLY

For your safety, the facility may not allow you to leave alone or drive yourself for any procedure requiring anesthesia. If you do not have an adult over the age of 18 to stay with you, the facility may cancel your surgery.

HSS is not responsible for travel expenses if the surgery is cancelled or rescheduled for any reason.

NAME: _____ PHONE #: (____) ____-_____

PRIMARY CARE PHYSICIAN: _____ PHONE #: (____) ____-_____

ADDRESS: _____

STREET

CITY

STATE

ZIP

HOW DID YOU HEAR ABOUT DR. MARVIN?

- Web Search _____ Social Media _____ Friend/Family _____
 MD Referral (name) _____ Phone # _____
 A patient of Dr. Marvin (name) _____

WHAT IS THE PROCEDURE OF INTEREST?

- ____ Endoscopic Sleeve Gastroplasty ____ Gastric Bypass (Roux-en-y)
____ Dual Gastric Balloons ____ Laparoscopic Sleeve Gastrectomy
____ Gastric Lap-Band ____ Unsure

SIGNATURE

DATE

PARENT SIGNATURE (if patient under 18 years of age)

DATE

COMPLETE MEDICAL HISTORY

What is your current weight? _____ LBS What is your current height? _____ FT _____ IN

Have you had previous weight loss surgery? No Yes

If Yes, Please provide following information.

Name of Surgeon _____ Surgery date _____ Procedure performed _____

List any medical **problems** you have for which you have seen a doctor or been **hospitalized**.

| ILLNESS | DATE | TREATMENT | OUTCOME |
|---------|------|-----------|---------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

- | | |
|--|--|
| Have you been diagnosed or treated for high blood pressure? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been diagnosed or treated for diabetes? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have high blood cholesterol? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have high blood fats or triglycerides? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had a Heart Attack? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you had an Irregular Heartbeat (arrhythmia)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you had stents placed in your heart arteries? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been diagnosed with asthma? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been diagnosed or treated for Sleep Apnea? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you sleep with a CPAP or BiPAP machine? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been diagnosed or treated for heartburn or gastro esophageal reflux (GERD)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had stomach ulcers? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had blood clots in your leg veins? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had a blood clot to the lung (pulmonary embolus or PE) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been diagnosed with Polycystic Ovarian Syndrome (PCOS)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you had problems with infertility? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have irregular menstruation? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been treated for Arthritis or Joint Pain? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been treated for Back Pain or Sciatica? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been diagnosed or treated for Gout? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Are you ever incontinent of urine when coughing or straining? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been anemic? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had iron deficiency or taken iron? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been diagnosed with Hypothyroidism? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had thyroid surgery? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you take thyroid replacement medication? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Have any of your close relatives been treated for the following:

- High blood pressure? No Yes
 High Cholesterol? No Yes
 Diabetes? No Yes
 Heart Attack or Heart Disease? No Yes
 Stroke? No Yes

List all surgeries and specify if done open or laparoscopic.

| SURGERY | DATE | REASON | OPEN OR LAP |
|---------|------|--------|-------------|
| | | | |
| | | | |
| | | | |

- Have you had your gallbladder removed? No Yes
 Have you had a hysterectomy? No Yes
 Have you had a tubal ligation or had your “tubes tied”? No Yes
 Have you had a hiatal hernia repair or Nissen Fundoplication? No Yes
 Have you had any operation on your stomach? No Yes
 Have you had a repair of an abdominal wall hernia? No Yes

List all current medications, including prescriptions, vitamins, over-the-counter, and intermittently used drugs. PLEASE PRINT.

| NAME | STRENGTH | FREQUENCY | PURPOSE | STARTED | DAILY? | AS NEEDED |
|------|----------|-----------|---------|---------|--------|-----------|
| | | | | | | |
| | | | | | | |
| | | | | | | |

- Do you take aspirin? No Yes
 Do you take Plavix (Clopidogrel)? No Yes
 Do you take Coumadin or Warfarin? No Yes
 Do you take Plaquinel or Methotrexate? No Yes
 Do you take any type of platelet inhibitor (i.e. effient or persantine)? No Yes
 Do you take any oral or injectable blood thinner? No Yes
 Do you take Prednisone or Dexamethasone? No Yes

List any allergies to medication and explain reactions you experienced.

Do you get chest pain when exercising? No Yes
 Do you get short of breath at rest? No Yes
 Do you experience irregular or excessively strong heartbeats? No Yes
 Do you sleep lying flat? No Yes
 Do you wake up at night short of breath? No Yes
 Have you had any blackouts? No Yes
 Do you get swollen ankles? No Yes
 Have you had easy or excessive bleeding from surgery or minor injuries? No Yes
 Have you had easy bruising? No Yes
 Do you have heavy periods? No Yes
 Are you still having periods? No Yes

Do you drink alcohol? No Yes
 How much alcohol do you drink a week? _____
 Do you use recreational drugs? No Yes
 Have you ever smoked tobacco products? No Yes
 If yes, how many years? _____
 How many packages of Cigarettes a day? _____

Have you been diagnosed or treated for depression? No Yes
 Have you been diagnosed or treated for Bipolar Disorder? No Yes
 Have you been diagnosed or treated for Schizophrenia? No Yes
 Have you ever received Psychiatric treatment? No Yes
 What was the diagnosis? _____
 When was your last treatment? _____
 Who were you treated by? Psychiatrist, Psychologist, or Physician (circle one)
 Physicians Name _____
 Physicians Telephone _____
 Physicians E-mail _____

Does your religion prohibit you from receiving blood products? No Yes
If you answered yes, would you consent to any of the following?
 Autotransfusion with your own blood (i.e. sell saver) No Yes
 IV infusion of Albumin No Yes
 Transfusion of Platelets No Yes
 Transfusion of Plasma No Yes

Sleep Apnea Self-Test

The quiz is designed to alert you to any problems resulting from poor sleep. Please answer the questions below. If you have had any symptoms in the past year, mark the box below and add up the total.

- (20) _____ 1. I have been told that I snore or I know that I snore.
- (-50) _____ 2. I definitely do not snore.
- (10) _____ 3. I have been told that I stop breathing when I sleep.
- (10) _____ 4. I wake up choking.
- (5) _____ 5. I sweat excessively at night.
- (-5) _____ 6. (If female and above is true) I have hot flashes related to my cycle.
- (2) _____ 7. I am tired and sleepy during the day even after 8 hours of sleep.
- (2) _____ 8. I wake up tired and unrested.
- (10) _____ 9. I suddenly wake up unable to breath.
- (5) _____ 10. I have fallen asleep while driving.
- (5) _____ 11. I am a restless sleeper (toss and turn a lot).
- (20) _____ 12. My neck circumference is more than 17 inches. (Ask office staff to measure if unknown)
- (5) _____ 13. I frequently have morning headaches.

_____ Total (more than 30 points suggests that you have SLEEP APNEA.)

DIETARY HISTORY

Medically Supervised Diet Programs
Check All that Apply

M.D. Name _____ **Office Phone** _____

- Medi-Fast
- Opti-Fast
- Mayo Clinic
- Physician or Registered Dietician Specific Diet Program
- Shots: B-6
 - B-12
 - Other
- Pills: Lasix (diuretic)
 - Xenical
 - Meridia
 - Other _____

NON M.D. SUPERVISED

- Weight Watchers
- Nutri-Systems
- Jenny Craig
- Diet Center

Print Patient Name _____

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this form, I authorize Dr. Robert G. Marvin to use and disclose the protected health information described below regarding my case for medical or financial purposes.

Patient Name: _____

Social Security: _____ D.O.B _____

Name (if different from patient): _____

Phone: _____ Work: _____

Address: _____ City: _____

State: _____ Zip Code: _____

The type of health information you may release subject to this authorization is as follows:

Non-Medical Individuals (Family/Friends) I authorize my Protected Health Information to be as follows:

Name: _____ Relationship: _____

Release my protected health information to the following person(s)/ entity:

**Houston Surgical Specialists
6330 West Loop South Ste. 610
Bellaire, TX 77401
Office: 713-993-7124
Fax: 713-963-0476**

HIV / AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical record.

Signature: _____ Date: _____

PLEASE USE THIS FORM AS A TEMPLATE FOR YOUR INSURANCE CARD

PROVIDE A FRONT AND BACK COPY

THEY MUST BE READABLE

Front Copy

Back Copy